

Trans Futures: A Consideration of Transgender Youth, Transgender Visibility, and Transgender
Citizenship

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I. Introduction: Imagining Future Trans Citizens

In 1987, the first specialized gender identity clinic for children and adolescents in the Netherlands opened its doors at Utrecht University Medical Center. After moving to VU University Medical Center in Amsterdam as part of the Center of Expertise on Gender Dysphoria, the clinic has experienced a considerable influx of referrals. As of 2012, nearly 400 children and 400 adolescents have attended the clinic with the mean age of referred adolescents also decreasing.¹ Though the researchers began this clinic with no official diagnostic criteria in place, their research, along with the experience and knowledge gained outside of the Netherlands, has led to the development of protocols for treating transgender youth worldwide. The specific protocol of this Dutch team has been widely published, and as they describe it, the “Dutch protocol” or the “Dutch approach” has “become proverbial in this field.”²

In this thesis, I am interested in looking at the ways in which the researchers and developers of this protocol have written about their approach to treating gender dysphoria and gender variance in children and adolescents. In looking at various research publications produced by this team, I want to illuminate how they discursively construct the ambiguous figure of the transgender child and how the clinicians, researchers who are writing treatment protocols, and parents of these children are all taking part in very complex projects that in some ways disrupt the idea of normative gender. The very fact of the Dutch protocol’s existence also signals exciting potential and promise for the lives of transgender youth, who indeed face sometimes impossible odds. When they arrive at the clinic, with the support of their parents, and with the

¹ Annelou L. C. de Vries and Peggy T. Cohen-Kettenis, “Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach,” in *Journal of Homosexuality* 59 (2012): 302.

² Ibid, 303.

³ Judith Butler, *Undoing Gender* (New York: Routledge, 2004), 39.

resources the clinic can provide, there is an envisioning of what Judith Butler calls a “livable life”: in a way, the Dutch approach is a realization of the possibility for a livable life and the political arranging of its institutional support.³

But this leaves us with the question of how “life” is to be defined, and this is largely a discourse that leaves us asking who is worthy of and included in such a life. Butler takes up this question of what is life, and what it means politically for us to consider what conditions make a life livable. When Butler writes, “it cannot be a good thing to invoke rights or entitlements to what one considers a ‘livable life’ if that very life is based on racism or misogyny or violence or exclusion,” she is pointing to the ways in which “life” and “human” have historical and political histories that contain normativities of whiteness, gender, sexuality, and class. Where a “livable life” or the claim for human rights is invoked, we also have other lives that are marked as unlivable, disposable, or not yet fully human because they are excluded and abandoned. In part, this thesis will argue that the conditions that create a livable trans life are inevitably founded upon extracting value from the disposal of racialized others.⁴

This thesis is a consideration of the state of transgender and queer politics, trans health care, and trans visibility. In a sense, I am concerned temporally with the past, which will be the topic of part II of this thesis. In part II, I will look at the site of medicine, science, and the construction of homosexuality in America and Europe and the diagnostic construction of gender identity as disorder. There, I am concerned with considering the ways in which queer people have conceptualized resistance in terms of visibility and the ways in which that visibility and

³ Judith Butler, *Undoing Gender* (New York: Routledge, 2004), 39.

⁴ See C. Riley Snorton and Jin Haritaworn, “Trans Necropolitics: A Transnational Reflection on Violence, Death, and the Trans of Color Afterlife,” in *The Transgender Studies Reader 2*, ed. by Susan Stryker and Aren Z. Aizura (New York: Routledge, 2013) and Elijah Ediv Edelman, “‘Walking While Transgender’: Necropolitical Regulations of Trans Feminine Bodies of Color in the US Nation’s Capital,” in *Social Justice: Queer Necropolitics*, ed. by Jin Haritaworn, Adi Kuntsman, and Silvia Posocco (New York: Routledge, 2014)

resistance subvert the norm, and the ways in which the norm responds by incorporating this queer subject by conceiving of acceptable ways for that queer subject to become visible.

Part III takes up the present but also points to the future by looking at how Dutch researchers imagine new embodiments of transgender youth, and also how the researchers manage the anxieties about gender normativity that surround the transgender child. In a way, these researchers imagine a proper way of being transgender and envision what a future transgender citizen can look like. My concern here is not to challenge the efficacy of the work being done, but instead to point to wider concerns about reinforcing a transnormativity—a normative, medicalized, and acceptable means of being trans by which a transgender person can gain citizenship and recognition from the state.

Part IV is about the politics of the present and the implications of this contemporary politics for the lives of transfeminine people of color, as well as the futures of transgender citizenship, transgender visibility, and trans liberation. This section discusses the centrality of racism to contemporary queer and trans movements and the necropolitics—meaning the politics of value in death—of both these movements and the forms of proper, patriotic, queer investments in the nation that these invoke.

All of these sections are tied together not only by issues of transgender visibility and queer and trans politics, but also by the question of how a transgender citizenship is to be defined. And what does the politics around such a citizenship look like? First, it seems necessary to discuss what is meant by citizenship, and why it is central to this project. While citizenship refers to how one stands in relation to the law, Lauren Berlant notes that citizenship is also a way of talking about “a relation among strangers who learn to feel it as a common identity based on

shared historical, legal, or familial connection to a geopolitical space.”⁵ The concepts of nation and nationality are particularly important to the concept of citizenship, and scholars such as Jasmine Puar are writing about queer desires for participation in the nation. Utilizing the term homonationalism— short for homonormative nationalism— Puar sees a collusion between U.S. nationalism and homosexuality, tied to rhetorics of patriotic inclusion that also formulate outsider terrorist others who threaten the nation and are, indeed, unable to be incorporated as citizens of the nation.⁶ Indeed, citizenship or the fact of citizenship does not actually mean that all are equally protected or fully conferred the benefits of citizenship. As Berlant notes, “the historical conditions of legal and social belonging have been manipulated to serve the concentration of economic, racial, and sexual power in the society's ruling blocs.”⁷ In order to deal with this, political struggle around citizenship has often led to theoretical understandings of different types of citizenship. Most relevant to the struggles of queer, trans, and feminist movements have been the concepts of sexual citizenship and cultural citizenship. Berlant defines sexual citizenship as “ the ongoing struggle to gain full legal rights for gendered and sexual minorities” and cultural citizenship as “the histories of subordinated groups within the nation-state that might not be covered by official legal or political narratives.”⁸ Both of these invoke belonging along the lines of the nation-state, but also invoke belonging in a transnational sense, especially given the increasingly globalized processes with which citizenship is now operating.

⁵ Lauren Berlant, “Citizenship,” in *Keywords for American Cultural Studies* (New York: New York University Press, 2014). <http://proxy.lib.ohio-state.edu/login?url=http://search.credoreference.com/content/entry/nyupacs/citizenship/0>

⁶ Jasbir Puar, “Mapping U.S. Homonormativities” *Gender, Place and Culture: A Journal of Feminist Geography* 13 (2006), 71.

⁷ Berlant, “Citizenship.”

⁸ Ibid.

Yet, these struggles over citizenship create racialized, sexualized, gendered, and working-class subaltern bodies that “bear the burden of representing the *desire for nation* generally.”⁹

Most crucial to the way in which I am thinking of citizenship is the inherent paternalism of citizenship, whether citizenship is something granted by birth or whether it is something granted through law and by the protection of the state at the supposed end of the political struggle for equal rights and protections. Berlant addresses this paternalism with her concept of “infantile citizenship.” In Berlant’s formulation, the infantile citizen is one who places trust in the nation to protect all people, and naively sees the nation as utopia.¹⁰ The adult citizen looks at the infantile citizen, who is seen as “unknowing,” with scorn and disgust, but at the same time feels admiration and the nostalgia for that same kind of “unknowing” patriotic idealism.¹¹ In a sense, transgender youth represent infantile citizens who are not yet fully transgender citizens. Yet, even adult transgender citizens, in a sense, are infantile citizens who have not yet received the full promise of citizenship from the paternal state.

Most central to Berlant’s look at infantile citizenship and political struggle is the status of political struggle in either resisting or reinforcing a public national culture. With national media and a culture of national memorialization and monumentalization, representations of nationality, there exists a mode of publicity that creates “the true face” of the nation. Thus, these modes of publicity exist as normative technologies of citizenship.¹² Political struggle in the form of marches, visibility, and collective activities do much to invert those collective performances that honor citizens, yet the very fact of this collective action is something very central to American national culture: it is when the nation is in crisis that Americans are expected to invoke such

⁹ Lauren Berlant, *The Queen of America Goes to Washington City: Essays on Sex and Citizenship*, (Durham: Duke University Press, 1997), 27.

¹⁰ Ibid, 27-28.

¹¹ Ibid.

¹² Ibid, 31.

massive political action.¹³ Furthermore, such actions become eclipsed because monumentalization becomes the national currency: the image is what is left to dominate national culture and national memory rather than the actual ideals and struggle of the movement.¹⁴

And what are we to gain from such an image? The image that is left is a vision of the idealized proper and patriotic citizen, whether that citizen be the white, cisgender and fully adult citizen, or whether that image represents the subaltern or infantile citizen. The image of a proper subaltern citizen creates the vision of how such a subaltern can be incorporated into citizenship by conforming or fitting into a normative mode of being visible that matches the image that can and has been incorporated into the logics of the national culture. This project is concerned with which images of transgender bodies are acceptable, or have the potential of being incorporated into the nation, and thus into full citizenship. In a lot of ways, the gender identity clinic is a site that reproduces what an acceptable future transgender citizen body will look like. However, there is a tension here that troubles this formulation of the medical institution's creating and maintaining normative ways of being.

As I mentioned before, it is important to attend to how medical intervention ameliorates a life that might have at one time seemed unlivable and devastatingly impossible. The Dutch protocol, in a lot of ways, offers us a great way to create livable lives for those transgender youth who are loved and needed in the world: it is a way of saving them from being swallowed up by the emotional devastation of gender dysphoria, and of saving them from death. Because for some transgender people, what is the alternative? Medical intervention can mean that a transgender person will not attempt suicide or that they may express and embody their gender identity in ways that abate their gender dysphoria. It means that a transgender life is livable and being lived.

¹³ Ibid, 52.

¹⁴ Ibid, 52-53.

This project therefore is not about demonizing the practice of transgender medical transition. Instead, I am arguing that the clinic becomes a privileged site for determining the status of the body within a transgender model of citizenship. Medical care is a contentious site of transgender citizenship because clinicians often erase the political economy of transgender healthcare, and the clinic as a place creating the institutional possibility of a livable life is ultimately built upon exclusion. This thesis is invested in opening the possibility for a trans liberation that is not centered around visibility or an idealized transgender subject. Rather, I will argue that political struggle for transgender liberation should be centered around the idea that there is no one mode of being visibly transgender, and that one's gender should not be at all discernible based on one's body. Additionally, I want to point to the ways in which such a liberatory logic is only possible through an anti-racist, feminist, and queer-centered approach that signals not exclusion vis-a-vis the creation of the visible, patriotic transgender citizen, but rather the destruction of a logic that privileges trust in the nation-state to eventually protect and incorporate transgender people as full citizens. In effect, trans liberation should be centered around creating new life-worlds, new ways of being that do not reproduce the harms of a desire for the nation.

II. Mapping Queer Resistance and Normativity

In thinking about the implications of medicalizing contemporary transgender identities, it is necessary to think about the history of queer identities living in relation to scientific and medical constructions of those identities. In particular, what strategies of resistance and what kinds of discourses have queer movements invoked against medicalization and pathologization?

Furthermore, how have these queer movements disrupted and recreated mappings of normativity and cultural ideas about proper citizenship? For example, in the 1951 release of the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) the American Psychiatric Association classified homosexuality as a “sociopathic personality disturbance” and then later in 1968 as a form of “sexual deviance,” and in 1970 as “Sexual Orientation Disorder.”¹⁵ Eventually, by the DSM-III-R in 1987, after nearly 14 years of outcry from gay and lesbian political groups and psychiatrists, homosexuality was completely removed from the DSM, and thus put an end—to some degree—to a troublesome history of pathologizing homosexuality.¹⁶

The DSM-III, however, included a new set of queer identities that had its own, history of pathologization and coercion within Western psychiatrics, though one that intersected. Listed under “psychosexual disorders,” the DSM-III included new diagnoses for Transsexualism and Gender Identity Disorder in Children.¹⁷ In this section, I will briefly discuss some of the discursive ties that other scholars have noted between homosexuality and gender deviance or “inversion” throughout the 19th-20th centuries. I will then briefly discuss the work of John Money with intersex and transgender people after 1950 and the debates surrounding a specific patient of his. Throughout, I will ask what is enabled and what is resisted when identities are scientifically constructed and medicalized, while also being attuned to the ways in which people strategically live under and organize around the construction of such identities in order to redefine the logics of visible citizenship. I will also discuss the emergence of Gender Identity Disorder, Transsexuality, and Gender Dysphoria to illustrate how the institutional regulation of gender and its reliance on the figure of the perverse child has historical and cultural ties to ideas

¹⁵Jack Drescher, “Queer Diagnoses: Parellels and Contrasts in the History of Homosexuality, Gender Variance, and the *Diagnostic and Statistical Manual*,” *Archives of Sexual Behavior* 39 (2010): 434-435.

¹⁶ Ibid.

¹⁷ American Psychiatric Association, DSM-III, 264.

about proper political citizenship. Finally, I will complicate the logic of a visible transgender body.

Sexual Inversion and Perversions

In culturally situating medical and scientific obsession with homosexuality in America and Europe, Jennifer Terry writes that medical and scientific discourses around the homosexual were largely tied to “cultural anxieties about protecting and managing modern democratic societies from disturbing incursions, inversions, and perversions.”¹⁸ At stake in medicalizing homosexuality in the late 19th century and early 20th century was finding the causation of such perversion.¹⁹ Indeed, modernity and increasing perversion became discursively tied to one another, thus driving an urge to etiologize, pathologize, and control homosexuality.²⁰ The first medical studies of homosexuality in 1860’s Western Europe conducted by Karl Heinrich Ulrichs and Magnus Hirschfeld perceived homosexuality to be a natural and evolutionary inborn anomaly of “sexual inversion.”²¹ By the 1880s, a second group known as “degenerationists” saw the manifestations of this inborn sex inversion to be a process of social degeneracy, conflating the process with other sources of supposed social disease along the lines of race and class. By the 20th century, Freud was calling into question this idea of homosexuality as “inborn” and instead regarded homosexuality as psychogenically an outcome of childhood experiences.²²

Whether arguing for homosexuality as an innate “natural” phenomenon or something perverse, all three of these scientific approaches to homosexuality point to two ways in which

¹⁸ Jennifer Terry, *An American Obsession: Science, Medicine, and Homosexuality in Modern Society* (Chicago: University of Chicago Press, 1999), 71.

¹⁹ Ibid, 73.

²⁰ Ibid.

²¹ Ibid, 43.

²² Ibid.

medicalizing queer subjects was an attempt to reinforce the rigidity of binary gender roles and to reinforce the superiority of heterosexuality and masculinity. Firstly, medicalization of homosexuality conflated biological sex, a cultural system of gender, and sexuality and enmeshed them into the formation of “sex” as an all-encompassing term.²³ Secondly, ideas about homosexuality focused on the homosexual body as a site of social deviance, and thus conflated this deviance with perversion within childhood, the family, and a certain social milieu of undesireables.²⁴

The first conflation came from 19th century European and American ideas about gender which saw heterosexuality as inevitably naturalized within gender roles. For example, a woman’s complete gender role in these national contexts hinged on her sexual passivity to an active male.²⁵ Though initially researchers lumped gender transgressions such as feminism or “transvestism” and “sexual perverts” with homosexuals under the term “sexual inversion,” after 1900 they began to specify and narrow sexual deviations, especially for men with the distinction between “transvestism” and “homosexuality.”²⁶ Researchers such as Freud also noted that inversion for men did not bear any implication for his masculinity, but homosexual women were still characterized as taking a “masculine” and “aggressive” role, and throughout the early 1900s lesbian couples were thought of as one woman taking the role of the “man” and the other taking the role of the “wife.”²⁷ George Chauncey notes that this particular medicalization of homosexual women also developed alongside anxieties around women’s movements that were

²³ Ibid, 181.

²⁴ Ibid, 266-267.

²⁵ George Chauncey, “From Sexual Inversion to Homosexuality: The Changing Medical Conceptualization of Female ‘Deviance’,” in *Passion and Power: Sexuality in History* (Philadelphia: Temple University Press, 1989), 90-92.

²⁶ Ibid, 92-93.

²⁷ Ibid, 94-96.

centered around ideas of independence, political power, and individual agency, which were seen largely as masculine ideals.²⁸

Such medical confluences of sexuality and gender persisted through the 1930s with the Committee for the Study of Sex Variants. The CSSV conducted a study in 1935 that brought together a large multi-disciplinary research team tasked with gathering information about the homosexual population in New York City.²⁹ This large team conducted invasive research into the sexual practices of homosexual men and women, even going so far as to document and take pictures of their genitals in order to denote anatomical differences and deviations.³⁰ In addition, this multidisciplinary team was working with the idea of “fluid sexes” which was not unlike Freud’s idea about homosexual men existing as “hermaphrodites” in which “‘secondary and tertiary characteristics’ of one sex often appeared in the other.”³¹ The Committee saw sex as an enmeshed framework of sex, sexuality, and gender, and theorized that “sex” was a polarized spectrum from masculine to feminine in which most men and most women fell naturally around the masculine and feminine poles.³² Ultimately, the CSSV was an effort to construct and maintain heterosexuality as a hygienic cultural institution maintained through the joint efforts of families and individuals while simultaneously positing homosexuality as an “undesirable outcome of modern developments.”³³

²⁸ Ibid, 104-105.

²⁹ Terry, 178.

³⁰ Ibid, 196-198.

³¹ Chauncey, 93. Freud did however, note that this was sort of mental “hermaphroditism” because as Chauncey writes, “there was no correlation between their appearance and homosexual desire in the case of men.”

³² Terry, 180-181. Terry notes, “These ideas were supported by recent endocrinological research that indicated significant hormonal similarities between males and females, by psychological research that revealed sex variance in personalities among those who seemed to be anatomically normal, and by anthropological research that suggested that sex roles were culturally contingent and varied from one society to another.”

³³ Ibid, 214, 266-267. Terry notes that the city as a site of modern development is one place where public hysteria over homosexuality became very prevalent, especially with the number of queer subcultures that

The focus on the family and childhood within the scientific construction of homosexuality during this period also went hand in hand with the idea that the working class, poor people, people of color, and political radicals (such as feminists) were more inclined toward sexual perversion.³⁴ Overall, the pathologization of homosexuality was about defining a dominant and patriarchal narrative of heterosexuality that ultimately could only be accessed by rigid and strict adherence to the prescribed gender roles coded along lines of race, class, and sexuality. As mentioned before, these rigid norms were also protective measures against perceived perverse others who threatened the stability of a moral democratic society. As Terry notes, it became about protecting the nation, and with the rise of McCarthyism anxieties about childhood vulnerabilities to sexual and political perversion at the hand of other socially undesirable subjects such as homosexuals and communists became a metaphor for the vulnerability of the American nation state to outsiders.³⁵ As Terry argues, these anxieties about homosexuality, though not scientific or medical constructions, were anxieties about what connotes a “proper patriotic citizenship.” Overall, scientific and medical constructions of homosexuality were constantly in conversation with and informed cultural norms and stigmas surrounding homosexuality. These ideas about homosexuality were important not only to a medical and scientific construction of gender and gender norms but also to those queer subjects who lived the consequences of scientific and medical constructions of queer identity and who learned to form their identities in strategic and resistant ways under these projects.

Terry’s look at the medicalization of homosexuality, including her look at how homosexual men and women willingly participated in the Committee for the Study of Sex

began to develop in places like NYC. Ultimately however, this hysteria and stigma were the reasons that many people decided to participate in the committee—hoping the study might debunk or get rid of some of the stigma.

³⁴ Ibid, 156.

³⁵ Ibid, 328.

Variants, shows how they were drawn toward and “constructed identities in relation to authoritarian knowledge being produced about them.”³⁶ But as Terry recognizes, and as we can see from the preceding examples, the scientific construction of an identity had an ultimately dire cost that adversely shaped political lifeworlds through pathologization, and both stigmatized and misunderstood the ways that queer lives and queer desires were actually lived and practiced. Queer politics centered on criticisms of biological reductive attempts at defining sexuality in the 1970s and 1980s, and their citation of alternative sociological and psychological views of homosexuality, such as those posited by Evelyn Hooker, shows the ways in which queer subjects lived in strategic relation to scientific authority.³⁷ Such a strategic positioning certainly became important in the eventual removal of homosexuality from the DSM, and reiterated the fact that gays, lesbians, and other queers could themselves acquire the agency to resist or invoke authoritative knowledge being produced about them. Furthermore, as homosexuality’s pathologization and its conflation with ideas about gender became further questioned and interrogated, researchers had new queer subjects to analyze, pathologize, and manage along the lines of gender normativity, which again returned to the familiar realms of childhood and anxieties over the protection of a rigid gender binary system from perceived modes of perversion.

Regulating and Assigning Gender

In 1972, John Money and Anke Ehrhardt embraced the popularized distinction between sex and gender, using sex to discuss anatomical and physiological attributes, such as genitals, and using gender to describe “a psychological transformation of the self— the internal

³⁶ Ibid, 69-70.

³⁷ Ibid, 373. Hooker emphasized that homosexuals were happy and fulfilled so long as they did not face homophobia.

conviction that one is either male or female (gender identity) and the behavioral expressions of the conviction.”³⁸ Second-wave feminists at the time were also making such a distinction, and along with Money and Ehrhardt they conceived of sex as physical traits and gender as “social forces that molded behavior.”³⁹ John Money’s distinction was arising out of his own work with intersex and transsexual “gender assignments.” Though many found this distinction to be liberating, researchers began to theorize about the regulation of gender identity and its formation. Money, along with his collaborators John and Joan Hampson, believed that the formation of gender identity in early childhood was extraordinarily malleable, while gender ambiguity later in life was a pathological problem.⁴⁰ In effect, doctors could “correct” intersex born infants along the lines of the gender binary and parents would have to monitor and socialize the child into their assigned gender identity of either male or female.

Money’s views became hailed as the most liberal and progressive forms of treating intersex individuals by the 1960s. However, his views would eventually come under fire by Milton Diamond in a debate that lasted nearly thirty years, all centering around the central figure of the highly popularized “John/Joan” case, which received media attention.⁴¹ John, who was a child under the care of Money and his colleagues, initially lost his penis in a circumcision accident. Money advised John’s parents that John should instead be raised as a girl, because of the lack of a “normal” phallus, and John was thus surgically altered to live life as a girl. However, John became very unhappy with the assigned gender and eventually transitioned to living life as a male. Diamond used this case to argue against Money’s contention that gender identity was created *only* from environmental factors and that infants are “psychosexually

³⁸ Anne Fausto-Sterling, *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York: Basic Books, 2000), 3.

³⁹ Ibid, 3-4.

⁴⁰ Ibid, 63-64.

⁴¹ Ibid, 66-71.

neutral” at birth, arguing that gender identity is formed through biological factors such as X and Y Chromosomes— something that intersex activists have since come to decry.⁴² Ultimately, the debates surrounding this case were centered not only around trying to discover how gender identity is formed, but also how gender is to be regulated through a medical and scientific mechanism of power. As Foucault notes, such power forms subjugation to the institution by control and ties subjects to their identities:

[An institution of power] that applies itself to immediate everyday life categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him that he must recognize and others have to recognize in him. It is a form of power that makes individuals subjects.⁴³

Writing on the same case, Judith Butler sees that this process makes the body become a point of reference “for a narrative that is not about this body but that seizes on the body, as it were, to inaugurate a narrative that interrogates the limits of the conceivably human.”⁴⁴ Furthermore, she notes that an inconceivability — that of someone’s being inconceivably one way or another— is conceived again and again through this narrative, and is constantly accounted for and interrogated by institutional power.⁴⁵ The constant interrogation and monitoring of John’s body and his gender identity throughout his life, and indeed the doctors’ interrogating of their own assumptions about gender identity, show how the norm is not a static entity, but rather is negotiated by John (the subject) and the institution. As Butler notes, John speaks his truth at the “limits of intelligibility” in that he invokes humanness by speaking and

⁴² Judith Butler, “Doing Justice to Someone: Sex Reassignment and Allegories of Transsexuality,” *GLQ: A Journal of Lesbian and Gay Studies* 7 (2001): 626.

⁴³ Michel Foucault, “The Subject and Power,” in *The Essential Foucault: Selections from Essential Works of Foucault, 1954-1984*, ed. Paul Rabinow and Nikolas Rose (New York: The New Press, 2003), 130.

⁴⁴ Butler, “Doing Justice to Someone,” 627.

⁴⁵ Ibid, 626-629.

positioning himself as intelligible outside of and in relation to the norm.⁴⁶ Additionally, she concludes that John invokes Foucault's idea of critique, in that John's issuing of critique risks his own desubjugation from the power of the institutional norm, *although* the norm sets the limit of the human and relies on John's critique to adjust and subjugate transgender people to forms of institutional power.

Ultimately, John's case and the debates around it, coupled with the history of homosexual identity formation in relation to the institution, show how queer identities form in relation to institutional power, invoking it or resisting it in various strategic ways, struggling to not only speak their own intelligibility, but also to have a say in, on their own terms, the ways in which their citizenship will be defined. These projects also point to the ways in which political and medical citizenship rely on the rigid maintenance of an oppositional, heterosexual gender binary through the disciplining and assimilation of queer subjects, in the name of setting limits on what a human can do and say, and what a human can look like. As I will illustrate in the next few pages in my discussion of Gender Identity Disorder in the DSM, these processes have been at play in claims for transgender citizens, and have had complicated implications for which transgender bodies are able to become citizens and be incorporated into the images of national culture.

Gender Identity Disorder in the DSM

With the publication of the DSM-III in 1980, doctors began to name gender deviance as a disorder, just around the time that homosexuality was becoming depathologized as such. The focus on gender identity rather than sexual identity also had much to do with the aforementioned distinctions now being made between gender, sex, and sexuality and the work being done by

⁴⁶ Ibid, 633-635.

clinicians and researchers like John Money who were establishing gender clinics and creating more public awareness of transgender individuals and the medical and surgical interventions that these clinics offered to these individuals.⁴⁷ However, the introduction of diagnostic categories along lines of gender variance was also becoming a project of disciplining queer subjects into acceptable and legible forms of medicalized citizenship.

The DSM-III marked a distinction between the gender variance of adults and that of children. In adults, the claim that one was not the gender that one was assigned at birth was known as “Transsexualism” and was listed under psychosexual disorders along with voyeurism, sexual masochism, and other sexual acts and practices that were seen as perverse at the time. Additionally, the DSM pointed to childhood as the source of a transsexual outcome: “Transsexualism seems always to develop in the context of a disturbed parent-child relationship.”⁴⁸ The writers of the DSM were here performing political work that pathologized transgender individuals as sexually perverse individuals who were the products of disrupted, heteronormative kinship— a topic I will return to in more detail in Section III. This statement points to a certain cultural project that posits the maintenance of familial ties as a crucial mechanism for producing proper, gender-normative citizens. Yet the writers of the DSM do not consider the culture of transphobia that exists within these familial structures. The “disturbed relationship” between parent and child could be the result of a culture of transphobia and rigid gender normativity that ultimately causes such disruptions to occur. However, this characterization nevertheless points to the ways in which a transgender outcome was seen as a failure of social reproduction, a failure of the family, and a failure to live up to the responsibility of citizenship.

⁴⁷ Drescher, “Queer Diagnoses,” 437.

⁴⁸ DSM III, 263.

The distinction between the category of Gender Identity Disorder of Childhood and Transsexualism and the way it marks a difference between children and transgender adults also shows how childhood is an anxious site for the production and maintenance of heteronormativity and gender norms. The writers of the DSM note that gender identity disorder of childhood may persist into transsexualism in adulthood but may eventually desist.⁴⁹ In the DSM IV-TR, published in 2000, one can see that this distinction persists, even though the diagnostic criteria are simply listed under the heading “Gender Identity Disorder” for both adults and children. Overall, the language used to describe Gender Identity Disorder points to the failure to develop appropriate, gender specific behaviors: subjects fail to live up the gendered criteria of social belonging, and thus of citizenship. In particular, this failure is noted in children’s ability to belong, their ability to develop relationships: “In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress.”⁵⁰ Additionally, the text stresses, “clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.”⁵¹ Thus, the child in question is expected to have a life in relation to the medical and psychiatric institutions that the DSM purports to serve. It says, in effect, that their lives can only be produced as livable under these conditions that pathologize them and subjugate them to the power of the clinic.

This creating of a transgender subject that must live in relation to the clinic, only to be produced in the logics of medicalization, has been a site for the struggle of transgender people to self-determine their own gender in ways that do not pathologize them. Much like advocates for the depathologization of homosexuality, LGBT activists focused their efforts on having Gender Identity Disorder removed from the DSM because the term “disorder” pathologizes trans

⁴⁹ Ibid.

⁵⁰ American Psychiatric Association, DSM-IV-R, 577.

⁵¹ Ibid.

identities and insinuates that transgender people are somehow “disordered.”⁵² However, some clinicians and trans advocates expressed concerns about removing the diagnostic criteria, because a diagnostic category is often needed for insurance companies to cover transition related medical expenses.⁵³ Eventually, after recommendations from trans advocates in the medical field, the work of the DSM-V Workgroup on Sexual and Gender Identity Disorders, and recommendations from the APA Committee on Gay, Lesbian, and Bisexual Issues,⁵⁴ the APA eventually dropped the “disorder” from its diagnostic classification. The new diagnostic category, “gender dysphoria” is meant to maintain a diagnosis needed for medical treatment and to remove the negative connotations that the patient is “disordered.”⁵⁵

The process and various actors involved in removing the word “disorder” from the DSM can be seen in parallel to the ways in which lesbian, gay, and bisexual subjects have lived in relation to and have resisted the knowledge being produced about them in an effort to fight for full citizenship. However, there are also different stakes involved with claims to transgender citizenship and transgender citizens’ relationship to the clinic and medicalization. For instance, many transgender people desire medical treatments, not as a corrective to a “wrong” body, but rather as a way of controlling and self-determining how they will express their gender identity. What is troubling, however, with the medicalization of transgender identities is how it reinscribes normative ideas about gender, the body, and power. Namely, the idea is that the legitimacy of one’s gender identity is always something given from above, from those who hold medical authority, and thus the authority over how the body is legally and societally defined. For

⁵²Drescher, “Queer Diagnoses,” 440.

⁵³ See Nick R. Gorton, “Transgender as Mental Illness: Nosology, Social Justice, and the Tarnished Golden Mean,” in *The Transgender Studies Reader 2*, eds. Susan Stryker and Aren. Z. Aizura (London: Routledge, 2013).

⁵⁴Drescher, “Queer Diagnoses,” 449-455.

⁵⁵ American Psychiatric Association, “Gender Dysphoria” Fact Sheet (American Psychiatric Publishing, 2013). <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>

example, nearly half of the states in the U.S. require surgery or proof of treatment for a legal gender change. In a sense, this is another mechanism of producing transgender citizens as infantile, in need of paternal guidance to become inculcated into what it means to be a proper citizen, how one can become a proper citizen, and what one's body must do in order to become a citizen.

Visible Transgender Bodies

In American national media, with the rising visibility of transgender people, the question of what a transgender body is has been at the forefront, showing a troubling image of transgender people within national culture *as* their bodies. Yet high profile transgender celebrities, such as the actress Laverne Cox, have been using their visibility to discuss transgender issues. Cox has also worked to fight this popularized preoccupation of transgender people, their bodies, and surgery. In an early 2014 interview with Cox and model Carmen Carrera on *The Katie Couric Show*, Couric posed invasive questions to both women about what surgeries they had undergone. Though Carrera deflected the question, when pushed to Cox and asked if she felt similarly, Cox responded:

I do feel there is a preoccupation with that. The preoccupation with transition and surgery objectifies trans people. And then we don't get to really deal with the real lived experiences. The reality of trans people's lives is that so often we are targets of violence. We experience discrimination disproportionately to the rest of the community. Our unemployment rate is twice the national average; if you are a trans person of color, that rate is four times the national average. The homicide rate is highest among trans women. If we focus on transition, we don't actually get to talk about those things.⁵⁶

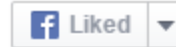
⁵⁶Katie McDonough, "Laverne Cox Flawlessly Shuts Down Katie Couric's Invasive Questions About Transgender People," *Salon*, January 7th, 2014, http://www.salon.com/2014/01/07/laverne_cox_artfully_shuts_down_katie_courics_invasive_questions_about_transgender_people/

In this instance, Katie Couric employs an idea of transgender people *as* their bodies, as gaining their identity from surgical intervention. In a way, she is presenting whom the nation imagines is a transgender person, and what, in the context of a large scale media interview, should be discussed about transgender people: their bodies and their surgical status. Cox's insistence that the focus should be on transgender experience rather than the transgender body is an articulation of a critical transgender politics that transgender people *are not* their bodies, but are people who feel a sense of belonging along certain points of experience and political interest. Cox herself is becoming a figurehead of national trans politics, and her increasing presence in the media in many ways points to the futures of transgender citizens as being incorporated into public national culture. Indeed, her presence and visibility is important in many crucial ways, especially because she actively sheds light on the violence being committed asymmetrically against transwomen of color.

In many ways, however, her visibility, and the visibility of other trans people in the media, has caused transgender activists to question the logics of visibility. Recently, on the internationally celebrated Trans Day of Visibility, Darkmatter, a trans South Asian artist collaboration that has gained a considerable amount of radical visibility in trans activist circles, posted a caution against the logics of visibility and what it means to be "visible" as a transgender person:

**Darkmatter**

Artist · 27,896 Likes · March 31 at 3:48pm · 🌐



This #TDOV (trans day of visibility) let's not forget that visibility can actually be lethal for many. Indeed, visibility for some is often contingent on erasure for others.

Many Black, indigenous, and other people of color who are trans or gender non-conforming may not have access to the resources and safety to "visibly" express our genders. When we do we often put our bodies on the line for even more familial, state, and interpersonal violence. Folks who are in detention centers, prisons, and/or living under occupation often are unable to be "visible" in their genders. Folks who are working class, surviving on the streets, navigating the foster care system, the shelter system, houselessness, may not be able to be visible in their genders. Young people who are confined to their homes and are constantly regulated by their families may not be able to be visible in our genders.

We should never create hierarchies where we celebrate "visible" trans people over others. Instead of blaming people for not being visible, let's dismantle the systems that prevent the majority of the world from accessing gender self-determination. Instead of shaming people for not being "out," let's trust people that they know what they need to do to keep safe. Instead of valorizing one type of trans visibility, let's challenge the standards of visibility themselves (which are defined by white supremacy, capitalism, ableism, and colonialism). Let's respect each person's self-identification, regardless of what they look like to us. Let's uplift the folks whose visibility does not align with conventional cis and white binary beauty norms. Let's uplift the gender non-conforming folks who are constantly erased not just by cis people, but also trans movements themselves.

You do not have to be "visible," to be trans.

All genders are valid, whether they are conventionally "visible" or not.

2,245 Likes · 43 Comments · 1,257 Shares

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This critique of the logics of visibility is not a way of saying that trans people who are visible in the media shouldn't be visible. It is rather a critique of the idea that one *has to* be visible at all or *should* be visible at all. Because what does it mean to be visible? Indeed, as I will examine in Part IV, visibility for trans-feminine people of color can mean death because of what their visibility represents— a disruption in queer desire for nation predicated upon an acceptable form

⁵⁷ Darkmatter's Facebook Page, accessed April 12, 2015, last modified March 31, 2015.

of visibility that the nation finds palatable. Thus, what this section has tried to illuminate are slices of a queer past of resistance to institutional and medical authority over queer identity. This has also been a look at the ways in which gender variant and queer citizens are inscribed into the norm, and invited into intelligibility, and thus into visibility on the terms of national culture and proper patriotic citizenship. Finally, this section has shown the tensions that are at the center of claims for transgender citizenship and the tensions that exist within trans politics over what trans visibility means.

III. Anxieties and Temporalities in the Clinical Treatment of Transgender Youth

The authors of the Dutch approach for treating gender dysphoria in children published their first results in 1998, detailing the preliminary findings after their treatment of a young transgender boy. In their 2012 twenty-two year follow-up, the researchers note that their patient is now happy, fully passing as male, and now a family doctor.⁵⁸ They also list the benefits of treating gender dysphoria⁵⁹/gender variance (GD/GV) at age twelve with puberty suppressing GnRH analogs, such as “buying time” for children to explore their gender identity, making certain forms of surgery less redundant and unnecessary, fewer problems with “passing” (meaning not being “visibly” transgender), and better overall satisfaction with surgical procedures than those who have a later start to their transition.⁶⁰ Thus, the researchers begin to detail what may be the object or the end goal of their work: the alleviation of a personal trauma

⁵⁸ Peggy T. Cohen-Kettenis et. al. “Puberty Suppression in a Gender-Dysphoric Adolescent: A 22-Year Follow-Up,” *Archives of Sexual Behavior* 40 (2011): 844.

⁵⁹ In the DSM-5, gender dysphoria, replacing the previous term “Gender Identity Disorder” is defined as a marked difference between an individual’s expressed/experienced gender and the gender others would assign to them, for a period lasting at least six months. In children, there must be a verbalized desire to be “the other gender.” “Gender Dysphoria Fact Sheet,” DSM-5 Website, American Psychiatric Association Publishing.

⁶⁰ Ibid.

(gender dysphoria), a pathway for a way of being, and producing a healthy gender normative subject that is visible in certain ways.

It is with this in mind that I begin to tackle the problematic of the clinical treatment of transgender youth. In looking at these texts, I will consider the ways in which the gender variant child's "arrival" is seen as something to be managed. This clinical intervention takes the ambiguous child or "childhood" as the object, imagining the final shape and effecting the child's trajectory across time and space. I will first discuss how this clinical ambiguity becomes constructed and narrated by both the clinical texts and the assumed narrative of a transgender childhood that clinicians demand of all transgender patients. I will then consider how these clinical approaches are centered around mediating the anxieties that surround the child, which are ultimately anxieties about the disruption of heteronormative fantasies of temporality. These clinical texts create the child as a discursively ambiguous figure who is coded along lines of race and class, which signals exclusion and barriers to care. I will argue that clinical approaches to treating transgender youth must begin to acknowledge the multiple ways that gender may be identified, expressed, and embodied. This section will consider who is imagined to be allowed to have treatment and who is not. In the act of discursively and materially constructing, imagining, and creating a future subject, who can become intelligible and which lives are, in the process, considered unintelligible, not fully human, and not fully able to fit into a rigid logic of visible, intelligible citizenship?

Constructing and Narrating a Transgender Childhood

Frequently cited by the World Professional Association for Transgender Health (WPATH) in their Standards of Care 7, the Dutch Approach to treating gender dysphoria in children and adolescents has received much praise and attention as a balanced and ethical

solution.⁶¹ Developed by an interdisciplinary team of mental health professionals, physicians, and surgeons, the first set of longitudinal results has just been published, revealing the effectiveness of this approach. The researchers conclude that their approach alleviates gender dysphoria and that their patients have an overall physical and mental health that is comparable to their peers.⁶² The approach consists of an extensive (and in many ways invasive) process of evaluation and assessment to determine if existing psychopathologies might be possible causes of gender dysphoria symptoms.⁶³ The clinicians also stress that the ideal patient is one who does not have concomitant psychiatric or family problems, and does not have other physical health problems such as obesity and smoking.⁶⁴ In addition, before age twelve, children must be monitored in case gender dysphoria abates, and they are encouraged to keep in contact with adults and peers of their “natal sex”⁶⁵ to “encourage a wider range of interests in objects and activities that go with the natal sex.”⁶⁶ There is also a pedagogy of embodiment in this “middle of the road approach” where the child must learn they will never be cisgender⁶⁷ should they socially and medically transition into their desired gender. This approach is considered to be “middle of the road” because the clinicians feel their approach is balanced, careful, and is a better alternative to simply denying the child’s wish to transition or simply allowing the child to

⁶¹ Eli Coleman et al., “Standards of Care for the Health of Transsexual, Transgender, and Gender-Non-Conforming People Version 7.” World Professional Association for Transgender Health, 2012, 6-7, and 108-109.

⁶² Annelou L.C. de Vries et. al, “Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment,” *Pediatrics* 134, 2014: 8.

⁶³ De Vries and Cohen-Kettenis, “Clinical Management,” 307.

⁶⁴ Ibid, 311-313.

⁶⁵ I am using this in quotations because I want to distance myself from the use of this term. It is the term that the clinicians use, but I would much rather use the term “gender assigned at birth.” Referring to “sex” has largely fallen out of fashion in the transgender community. Transgender people oppose such characterizations of gender because they can be used to invalidate their gender identity, and places focus on physiology and the body rather than the gender identity of the person.

⁶⁶ Ibid, 308-309

⁶⁷ They will never be cisgender, meaning they will never identify as the gender they were assigned at birth.

transition without careful intervention, attention, and pedagogy. At the age of twelve, the patients are allowed to take hormone blockers to delay puberty, and after extensive evaluation, at age sixteen they may begin taking hormones, and eventually they will be able to undergo gender reassignment surgery. As previously mentioned, the desired outcome is a healthy, gender normative subject who is “adequate” or passing. For example, the Dutch researchers note that one of their first patients, now well into his thirties, is “adequate” in his masculinity,⁶⁸ meaning that the patient, thanks to the clinicians’ intervention, has successfully been integrated into the norms of masculinity.

So what is at stake in integrating this patient into the norm of masculinity? On one hand, this patient is able to access a medical and discursive technology that will shape him and produce him in ways that allow others to know him as he knows himself. Considering Judith Butler’s essay, “Doing Justice to Someone,” we might say that this patient speaks and insists on himself outside of the norm, emerging as fully human, and creating intelligibility outside of the accepted norms of the intelligible.⁶⁹ We can say that these norms of intelligibility are also the norms of visibility. In this way, this patient is able to become visible at the *limits* of the norm. However, the patient is, in many ways reinscribed into gender normativity: this medical technology offers a way of being that will erase most signs of being transgender and indeed implies that this is a requisite for a transgender person to become satisfied, and thus healthy. Here, trans is seen in opposition to cisgender, and implies that passing and being invited back into *cisnormativity* is the desire. Here, I use cisnormativity to describe those gender norms that contain the assumption of gender *as cis*. For example, we could see the assumption that someone is cisgender as a cisnormative assumption.

⁶⁸ Cohen-Kettenis et. al, 844.

⁶⁹ Butler, “Doing Justice to Someone,” 633.

As A. Finn Enke and other trans-studies scholars note, “trans theoretically inheres movement and change, or space and time” while the term cis’s “peculiar ontology erases location and effects through time and space: to preserve the status of cis as non-trans, trans must never have been or become cis but instead be consistently trans across all time and in all spaces.”⁷⁰ Even though the clinic wishes to invite this patient into gender normativity, it nevertheless reinforces to the child-patient that they must understand and accept the reality of their transness. In a sense, this pedagogy of transness positions cis as a reality within reach, yet still as something impossible and actually unreachable. Yet, I would argue that this is also largely a function of the power of cisnormativity, and the privilege that comes with being cisgender. The clinicians equate trans with medicalization, technology, intervention, and temporal disruptions of gender. Cis on the other hand, acting as the norm, is desired, natal, and consistent: its temporality is assumed, always present, and invisible to us due to the pervasiveness of assumptions about gender that are informed by the norm. The cisgender body is held as the natural, normative standard against which a trans body is to be compared. And indeed, the idea that one’s gender is contained within the body, within a rigid standard of visibility and intelligibility, is itself a function of a cisnormative logic that tries to read and define what a transgender body should look like.

Clinicians also create their own assumptions about the timeline of a trans experience, creating their own norms of temporality. In the case of treating transgender children, it involves imagining a future subject and a future set of embodiments. I want to consider what happens when a subject is imagined and who is imagining the subject. This imagining of the child’s

⁷⁰A Finn Enke, “The Education of the Little Cis: Cisgender and the Discipline of Opposing Bodies,” in *Transfeminist Perspectives in and Beyond Transgender and Gender Studies*, ed. by A. Finn Enke (Philadelphia: Temple University Press, 2012), 73-74.

future is conducted from certain standpoints of power, whether it be the parents who must make decisions on the child's behalf⁷¹ or the clinicians who work to create institutional knowledge and interventions. Reading Sara Ahmed's *Queer Phenomenology*, I think of these positions as *orientations* from which we imagine others. For example, Sara Ahmed writes about the position of whiteness, and how whiteness is an orientation that puts certain objects within reach.⁷² She notes that these objects are not just physical objects, "but also styles, capacities, aspirations, techniques, even worlds."⁷³ We could even think of whiteness as an orientation that puts the clinic and its services and technologies within reach. Along these lines, she thinks about whiteness and the institution. The institution can be seen as "meeting points [...] where different 'lines intersect' and where lines cross with other lines to create and divide spaces," where whiteness requires us to be "in-line" and not deviating from the norm, and to "pass" as middle-class and straight.⁷⁴ Here, Ahmed is talking about the ways in which institutions are centered not only around whiteness, but a vision of heterosexuality that is itself interwoven with whiteness. It is a vision of the proper patriotic citizen who we imagine the institution to serve and who we imagine to reproduce the society that reifies institutional power: a white, cisgender and heterosexual citizen.

Whiteness is also inherited and possessed, signaling certain *promises of return* that involve both political and affective economies.⁷⁵ When thinking of the clinic as an institutional space in which multiple lines intersect, or perhaps itself being one that is oriented around

⁷¹ Jack Drescher and William Byne, "Gender Dysphoric/Gender Variant Children and Adolescents: Summarizing What We Know and What We Have Yet to Learn," *Journal of Homosexuality* 59, no. 3 (2012): 502. The authors continually stress throughout that children are consistently at the mercy of their parents and whether or not the parent will allow the child to get help.

⁷² Sara Ahmed, *Queer Phenomenology: Orientations, Objects, Others* (Durham: Duke University Press, 2006), 126.

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Ibid, 128-129.

whiteness, we might recognize how certain “orientations” and “inheritances” create the horizon of “what a body can do,” whereas “what a body can do” is defined by what a body *does do*. As per Ahmed, we can think of this theoretical formulation in terms of working our muscles: “The more we work certain parts of the body [...] the more work they can do[.] The less we work other muscles, then the less they can do.”⁷⁶ This can also be thought of in terms of gender, especially if we think about clinicians developing technologies that work to shape how our gender is expressed. “What a body can do” is the horizon, a space of possibilities that is consistently limited by and implicates the past as it accumulates and leaves traces on the body. Thus, the horizon is a future, something presenting the possibilities of our movements within society based on what our bodies have already “done” or what has been done to our bodies.

The concept of childhood could be thought of as a technology in the clinical setting, and thus a “straightening” device which has the productive power of producing a bodily orientation and creating limits on what one can do. Indeed, childhood becomes important for any transgender person trying to transition within the medical complex. Those who undergo transition in adulthood are expected to go through gender therapy where they construct a certain transgender narrative of childhood. Such a process reinforces a normative trans temporality, which has implications for what a transgender child looks like and how one experiences a transgender childhood. Dean Spade’s essay “Mutilating Gender” is a discussion of the expectation that one must have had a transgender or gender deviant childhood to be “truly” transgender. Looking through a Foucauldian lens, Spade sees the expectation of a trans childhood narrative largely as a regulatory mechanism of governance and disciplinary power, but

⁷⁶ Ibid, 60.

also as a mechanism that operates along lines of race and class.⁷⁷ Using his own narrative of seeking help, Spade details his own lack of knowledge that he was trans in early childhood. He was unaware, because what most affected him as a child was the fact that he was poor and on welfare.⁷⁸ Thus, Spade wants to reject the narrative of a gender-troubled childhood, and notes:

The self determination of trans people [becomes] compromised by the rigidity of the diagnostic and treatment criteria, [while] at the same time, this criteria and the version of transsexuality it posits produce and reify a fiction of normal, healthy gender that works as a regulatory measure for the gender expression of *all* people.⁷⁹

In turn, Spade also sees the treatment criteria as limiting the potential of trans people to threaten and disrupt the dichotomous gender system— because gender is not a rigid binary. Gender is lived, experienced, and identified in various ways and those who are creating and upholding the standards of clinical care may not realize just how various it is. Additionally, this reinforcement of the regulatory mechanisms of gender produce the fiction of a normative, healthy gender not just for trans people— we all utilize social technologies that produce gender. These technologies are material, discursive, and various. Cisnormativity and perhaps an emerging transnormativity (a normative way of being transgender) is something that produces a fiction about what technologies are indeed acceptable. For example, we can see the medical institution as an authoritative place where gender is produced and legitimated, especially at birth, but also as a place that, in the U.S, largely has control over whether a person can be recognized as their gender by the law. As mentioned in Section II, contemporary trans politics is largely a critique of the aforementioned logic. Again, trans politics is a critique of the idea that trans people are their bodies, and thus only legible by expressing their gender in a rigid, regulatory logic.

⁷⁷ Dean Spade, “Mutilating Gender,” in *The Transgender Reader*, ed. by Susan Stryker and Stephen Whittle (New York: Routledge, 2006), 319-320.

⁷⁸ Ibid.

⁷⁹ Ibid, 329. My Italics.

Furthermore, the discursive construction of the transgender-child-as-patient by the Dutch researchers plays a part in reaffirming the whiteness of the medicalized transgender narrative, simply through what it *doesn't* discuss. The study is conducted at a gender identity clinic in Amsterdam and they do not note the race of the participants nor their economic background. The study does not concern itself with the political economic aspects that may affect how one arrived at the gender identity clinic in the first place. This is, however, a result of the localized nature of the study, and the authors note that transgender individuals in the Netherlands “do not need to suffer from incomplete or inadequate treatment” because nearly all of the treatments are covered by insurance.⁸⁰ This is perhaps where the method and the efficacy of the study meet their limits: the moment of the protocol’s mobilization in an international context where different systems of medical citizenship and clinical practice are at play. In turn, without acknowledging the conditions of the transgender child’s arrival in the clinic—which Ahmed notes is shaped by political economies and personal histories⁸¹ — the standards of clinical treatment as they now stand, and the technologies they use to create gender along a rigid binary, risk performing the complex and inherently political work of imagining who can and who cannot be seen as a citizen. Attaining citizenship in such a model is having one’s gender identity *legitimated* on the terms of the medical complex. Thus, the technologies that maintain the boundaries of what a transgender childhood looks like or can look like is the work of producing the horizon and of producing what is in reach—it is marking what a body can do and the ways in which that body can be incorporated into a mode of citizenship.

⁸⁰ de Vries and Cohen-Kettenis, “Clinical Management,” 315.

⁸¹ Ahmed, 62.

Anxieties and Disrupted Temporalities

Within the practice of Dutch approach the child in treatment is constructed as a very ambiguous figure—a troublesome figure for which the clinics must develop a solution. We could say, however, that the figure of the child is consistently constructed as troublesome because of the fantasies and anxieties adult citizens⁸² and parents attach to children and the concept of childhood. The anxiety and the social projection of a future onto a child is made especially knowable and apparent when children transgress in some way: transgressions make the fantasy clear to us by disrupting our own projection of it and by threatening not to fulfill it. The assumption that a child is “cis” assumes a certain temporality, making cisgender invisible and ever present, and the transgression both disrupts this assumed temporality and makes the presence of the existence of such norms visible.

Jose Esteban Muñoz would say that this transgression is what makes a subject queer, insofar as queerness and queer embodiment “are the affective results of being outside of straight time.”⁸³ Muñoz defines “straight time”—with the pun on “straight” implicating heteronormativity—as follows:

Straight time tells us that there is no future but the here and now of our everyday life. The only futurity promised is that of reproductive majoritarian heterosexuality, the spectacle of the state refurbishing its ranks through overt and subsidized acts of reproduction.⁸⁴

Additionally, Muñoz sees straight time as linear and self naturalizing, whereas queerness is “a stepping out of the linearity of straight time.”⁸⁵ He also sees queerness as a horizon, or a

⁸² This refers back to the introduction and my discussion of Lauren Berlant’s conception of “adult citizens” who look upon “infantile citizens” with admiration and nostalgia because of their fierce patriotism and trust in the nation.

⁸³ Jose Esteban Muñoz, *Cruising Utopia: The Then and There of Queer Futurity*, (New York: New York University Press, 2009), 25.

⁸⁴ Ibid, 22.

“not yet here” that offers a way of stepping out of “the temporal stranglehold,” offering a new political horizon for queerness in the face of the *presentness* of heteronormativity. Even though Muñoz is focusing on sexuality rather than gender, the transgender body also performs this queer disruption of stepping out of straight time and anxieties around transgender bodies are often discursively tied to anxieties around the homosexual body. This is illustrated in the Dutch approach where parents discursively attach gender variance with homosexuality. The researchers note, “Adults, whose parents had indicated that their children either showed gender variant behavior or expressed the wish to be of the other gender, more frequently indicated that they were either homosexual or bisexual.”⁸⁶ Thus, gender dysphoria is also attached to sexuality in children and the study claims that some patients’ gender dysphoria will abate at puberty.⁸⁷ A transgender child exists as a queer figure not only because it disrupts temporal logics of straight time, but also because of the ways in which gender is often experienced in relation to sexuality and because of gender’s discursive tie to non-normative sexuality.

For Judith Butler, the discursive tie of gender and homosexuality is deeply embedded in a historical system. On the relationship between gender, desire, and sex, she theorizes that not only does the heterosexual institution assume and require an oppositional and binary gender system, it presupposes that gender is a reflection and expression of desire for the oppositional—the unity of sex, gender, and sexuality can only be expressed in these terms of oppositional heterosexuality.⁸⁸ The compulsory aspects of heterosexuality—and indeed its naturalized assumptions of temporality—are made apparent when disrupted by a deviant subject. This disruption troubles the parent because heterosexual kinship expects gestures of return and

⁸⁵ Ibid, 25.

⁸⁶ De Vries and Cohen-Kettenis, “Clinical Management,” 306.

⁸⁷ Ibid.

⁸⁸ Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990), 22.

reciprocity. As Ahmed notes, a subject becomes indebted to the heterosexual familial unit because it has supposedly produced the good life and a subject's future is seen as a social good.⁸⁹ For Ahmed, this is the force of Marcel Mauss' concept of the gift, whereas "the demand for return acquires force, while the demand to return accumulates 'the force' of the gift."⁹⁰ Thus, returning the gift extends the investment. Ahmed says that heterosexuality is seen as "the future of the child" and even "the gift of life itself," to which a child is endlessly indebted. Children are expected to return the gift through compulsory heterosexuality, while those who do not return it are "seen as bad debt, as being ungrateful, as the origin of bad feeling."⁹¹

This bad feeling or scorn, this feeling of "bad debt" is important to consider in the clinical treatment of transgender children. Indeed, these children are queer subject who are imagined to have already failed to make imagined gestures of return to heterosexual kinship in time. When a child is seen as failing to return the gift of life with compliance to gender normativity and heterosexuality, how can transgender children imagine different possibilities, horizons, or a set of possible queer embodiments that they too could inhabit? The gift and social promise of heterosexuality, and indeed gender normativity, are seen as an inherited ways of inhabiting and extending into space.⁹² This space, perhaps, can be conceived in terms of citizenship wherein gender normativity and heterosexuality are seen as inherited ways of inhabiting citizenship and extending into citizenship. The space of heterosexual kinship posits heteronormativity as the guarantee for citizenship and thus the guarantee of social protection, wealth, and future by virtue of heteronormativity's presentness, its pervasiveness in the here and now.

⁸⁹ Ahmed, 21.

⁹⁰ Ibid, 86.

⁹¹ Ibid.

⁹² Ibid.

We might consider what technologies are involved in regulating the fantasy or the “gift” of gender normativity and heterosexuality. The medical complex is one site that produces the fantasy from the beginning. Doctors assign a gender at birth, and for intersex children who are born with abnormal and ambiguous genitalia, this assignment involves performing harmful corrective surgery in order to make the child fit into the category of either male or female. The heterosexuality and the future of the child is one that is both assumed and created through intervention. Katrina Roen, writing about intersex corrective genital surgery, sees the process of correcting abnormal genitals as a process of imagining the future subject, which in turn projects the parents’ fears and ideas about normativity and desire onto the child.⁹³ The case of intersex, like the case of anxieties around transgender youth, also contains anxieties around a queer embodiment. While intersex intervention at birth tries to close off the possibility of a queer embodiment,⁹⁴ the clinical intervention of transgender youth is about managing and balancing a set of future embodiments, yet nevertheless *reinscribing* the hope of a normative embodiment. In both cases, the medical intervention can be read as a technology to manage and hope for the return of the gifts of kinship.

The hope that the child will still be gender normative and return the gift can be seen in the ways that researchers write about gender variant children. As mentioned before, transition involves teaching children that they will never “have been born in the body of the gender they desire”: they will never be cisgender and thus they will never fully capture that which they desire.⁹⁵ Also the clinicians insist that the children have healthy examples of their “natal sex” in order to keep “both” possibilities open, and as such keeping open the possibility of the return—

⁹³ Katrina Roen, “Clinical Intervention and Embodied Subjectivity: Atypically Sexed Children and their Parents,” in *Critical Intersex*, ed. by Morgan Holmes (Farnham: Ashgate, 2009), 21.

⁹⁴ Ibid, 34.

⁹⁵ de Vries and Cohen-Kettenis, “Clinical Management,” 308-309.

if not in terms of heterosexuality, but at least in terms of gender normativity. This is not to say that the possibility shouldn't exist, because indeed it does, but the clinical criterion nonetheless reflects a policing and pedagogy of gender variant children to consider their own social legibility and the social consequences that could arise from the child's gender transition.⁹⁶

In addition, texts that raise ethical concerns surrounding the clinical approach express anxieties about what puberty suppression and undergoing transition might do to the child. Edward Stein, a professor of law director of the Family, Law, Policy, and Bioethics Program at Cardozo School of Law at Yeshiva University, argues that experts do not yet know whether or not puberty suppression will risk pushing the child towards genital reassignment surgery: in other words, he is asking us to account for all the ways in which a transition could be avoided.⁹⁷ He thus implies, that a transgender outcome, though acceptable, is not really a desired outcome.

There is also a pedagogy of time and futurity involved in the clinical approach: the child and the adults must understand the reversibility of some procedures, and the irreversibility of others. Puberty suppression is a completely reversible procedure, whereas gender affirming surgeries are not. Constructing a timeline of treatment in which the children are allowed to undergo treatment, heavily based on ideas of when they can fully consent to a reversible procedure, also creates complex legal and ethical considerations. Christine Milrod notes that, even though the WPATH Standards of Care version 7 recommends waiting until legal adulthood until completely irreversible surgeries can take place, doctors continually find themselves bound by an ethical dilemma, considering that a child might be in dire need of the surgery before legal

⁹⁶ Ibid.

⁹⁷ Edward Stein, "Commentary on the Treatment of Gender Variant and Gender Dysphoric Children and Adolescents: Common Themes and Ethical Reflections," *Journal of Homosexuality*, 59 (2012): 491-492.

adulthood.⁹⁸ Milrod notes that transgender teens are more likely to be victimized than their counterparts, more likely to feel socially alienated, more likely to report severe anxiety about taking part in and exploring romantic relationships as a result of their inability to undergo surgery, thus contributing to the suffering caused by gender dysphoria.⁹⁹ Yet, these ethical anxieties around reversible and irreversible procedures are all anxieties about the possibility of regret, i.e. that the child will come to regret their transition, despite the fact that the longitudinal Dutch study did not find any patients who did. This points to the efficacy of the study and points to the ways in which transgender youth can have livable lives, and can be a participant in determining how their life will be lived.

Yet, the Dutch approach and Stein's text still leave us asking questions about what kind of life can be lived, and when such a life is allowed to be lived. Despite its efficacy the child in these texts is thought of as someone who cannot self-determine their social position until the age of 18, someone who must be protected and have guidance. Yet there are incongruences between the lived reality of being a transgender adolescent who is harmed and at risk in so many ways, and the laws and restrictions being produced about them that determine when and how they are allowed to give further content to the ways in which they want to embody their gender. Of course, we want to protect children, especially those who are going to have to face a harsh transphobic social world in which the odds are stacked against them. But we can also account for the ways in which they have a voice and a right to the self-determination of their gender, their time-line, and their future, which may not necessarily be fully compatible with the norms of the gender binary or the norms of the protocol.

⁹⁸ Christine Milrod, "How Young is Too Young: Ethical Concerns in Genital Surgery of the Transgender MTF Adolescent," *The Journal of Sexual Medicine* 11, no. 2 (2014): 339.

⁹⁹ Ibid, 340-341.

A Livable Life?

There is an imagined outcome in the clinical treatment of transgender children. The goal is to produce a healthy subject, who is gender normative and fully “passing” in their gender role through treatment and the pedagogy of the possibilities of living life on the terms of the gender binary. The emphasis on the gender binary and social gender roles reinforces the possibilities of embodiment along lines of the binary, and indeed poses an oppositional relationship between the gender one “desires” and one’s “natal sex” which ultimately is a reinforcement of a rigid binary gender system. Thus, clinical treatment of the child revolves around the managing of social and ethical anxieties of closing off more desirable heterosexual, cisnormative embodiments and the opening of queer embodiments.

Despite the troubling aspects of the researcher’s attempts to find the sources of gender dysphoria and the assumptions about queer subjects, gender, and embodiment that it reinscribes, the approach they provide is still a “queer practice” that does offer alternatives to an unlivable life and proves that transgender lives, whether adult, child, or adolescent, are livable and are being lived. However, instead of being anxious about queer embodiments and temporalities, we need to recognize those embodiments as legitimate, desired, and infinite in the ways that they could possibly deviate from the gender binary. Such a logic should be included in the treatment protocol. Incorporating these realities could be a transformative world making project: we might realize and appreciate that a child’s life should not have to return the gift or that children do not have to express gender on the terms that clinicians and adults set. We might also recognize how *we all* have bodies that “do” and shape the possibilities of our futures, even as adults.

Yet we also have orientations and inheritances that position us and put possibilities and worlds within our reach that are the results of political economy. Noting the political economy

of the medical complex in the United States, Norman P. Spack, an endocrinologist and co-founder of the Gender Management Service at Children's Hospital Boston discusses his own use of the Dutch Approach. Whereas the authors of the Dutch Approach note that in the Netherlands, care is covered by insurance, Spack asks the pointed question, "How frequent is buyer regret?"¹⁰⁰ Indeed, the economic aspects are increasingly becoming a concern, especially in recognizing that problems of transgender homelessness (including trans youth homelessness) are related to a lack of medical expertise on transgender health care in the medical complex, economic barriers to such access, and a general lack of cultural understanding and acceptance of transgender identity.¹⁰¹ The National Gay and Lesbian Task Force detail some of the statistics highlighting the lack of access to care: nineteen percent of transgender people in the U.S. lack any form of health care with black people showing the least access to insurance, nineteen percent were refused treatment, twenty-eight percent reported being verbally harassed in a medical setting, and one-fourth delay needed care because of discrimination from medical providers.¹⁰² Despite these barriers, a lot of respondents report accessing transition-related care, although most are not able to undergo gender related surgeries that they desire because most insurance plans exclude them from "necessary" care and some insurance plans exclude access to hormones.¹⁰³ Transition related expenses are not covered by medicare and are excluded in the Affordable Care Act. These barriers also compel respondents to find other ways of finding income to make up for lack of employment due to discrimination and to cover transition costs, including selling drugs or sex

¹⁰⁰ Norman P. Spack, "An Endocrine Perspective on the Care of Transgender Adolescents," *Journal of Gay and Lesbian Mental Health* 13 (2009): 317.

¹⁰¹ Shane Spicer, et. al, "Introduction: Special Issue on Homelessness and the Transgender Homeless Population," *Journal of Gay and Lesbian Mental Health* 14 (2010): 267-268.

¹⁰² Grant, et al. "National Transgender Discrimination Survey Report on Health and Health Care," *The National Center for Transgender Equality and the National Gay and Lesbian Task Force* (October 2010), 4-8.

¹⁰³ Ibid, 10.

work, which primarily affects transgender women of color, and leads to high rates of police abuse and rates of incarceration higher than that of the general population.¹⁰⁴

The health care disparities that transgender people in the United States face are indeed linked with ideas about gender normativity, health, and the temporal disruptions that come from stepping out of the self-naturalizing and assumed logic of straight time. At stake in the medicalization of transgender youth is imagining what futures they will inhabit and in what ways they can inhabit those futures. Clearly, the Dutch Approach is widely celebrated for its efficacy, but its success nonetheless relies on producing ways of inhabiting intelligibility that are not fully accessible. As mentioned in the introduction, the clinic produces “a livable life,” but we must account for what counts as life itself. The Dutch approach is a realization of the possibility for a livable life and the political arranging of its institutional support.¹⁰⁵ However, the conditions for such a life are also troubling, “if that very life is based on racism or misogyny or violence or exclusion.”¹⁰⁶ And of course, a gender identity clinic for children and the practice of the researchers are based on exclusion because they do not address the political economy of accessing care as a trans health concern. Indeed, they erase the traces of such a political economy. Thus, it becomes less palatable to perceive of celebrating lives being lived, when the living of such lives contains the exclusion and the abandonment of other lives, namely trans lives of color.

What I have tried to address here is two-fold. Firstly, I hope that this section has begun to address the ways in which some lives are made livable by the creation of treatment protocols, and some lives are indeed made unlivable by the very conception of those protocols because the

¹⁰⁴ Grant, et al. “Injustice at Every Turn: A Report on the National Transgender Discrimination Survey,” The National Center for Transgender Equality and the National Gay and Lesbian Task Force (October 2010), 65-163.

¹⁰⁵ Judith Butler, *Undoing Gender*, 39.

¹⁰⁶ Ibid.

conditions that create “livable lives” are made possible through institutions built upon racism and exclusion. Secondly, I have addressed the ways in which Dutch researchers play a role in providing valuable care for young transgender people but nevertheless reinforce the authority of medical institutions over trans bodies and reinforce ideas of trans people as their bodies.

What needs to be addressed and done away with is the rigidity of clinical criterion for all trans people, and for space to be made for trans people to have a voice in deciding what transgender citizenship can look like with or without the medical institutions and their expertise. The role of clinicians is to provide the tools for gender expression which some may find to be completely necessary, and central to their health. Yet clinicians should also address what is most important in providing new ways for transgender children to inhabit space and allow all transgender people, including children and adolescents the right to self-determine their gender expression. The clinic and what it provides is one way to get there, but it does not have to be the only, regulatory mechanism through which transgender people can produce themselves as fully intelligible. In fact, as already discussed in section II, transgender activists are challenging the idea that trans people have to be intelligible or visible at all. Ultimately, intelligibility is narrowly defined, culturally and socially. What might be more liberating is emphasizing that many transgender people do not experience gender as a rigid, defined unit of their subjugation, of their citizenship, and their place within society and nation, but as affective, emotional, not fully quantifiable by language, and outside of the logics of the heterosexual, gender normative citizenship that defines which bodies are intelligible.

IV. Race, Trans Necropolitics, and Transgender Citizenship

This final section further takes up the overarching issue of the other sections in this thesis: citizenship. In Section II I discussed the ways in which queer citizenships in America have historically articulated resistance to certain scientific authority and the invocation of other scientific authorities as a means to self-determining the ways in which a queer citizenship would be defined, as well as the ways in which trans politics posits a critique of the logic of visibility. Additionally, access to legitimized citizenship has also been a complex process of rearticulating, transgressing, and reinscribing the norms. Cultural ideas of proper political citizenship have also reflected anxieties about the vulnerabilities of childhood, the nation, and heteronormative social reproduction to the perverting influence of an internal queer other. Section III looked closely at the language used by Dutch doctors in the treatment of transgender youth in order to discuss the ways in which the child in the clinical setting is constructed in ambiguous ways that are coded along lines of race, class, and sexuality. In addition, my discussion of temporality brought up issues of heteronormative kinship, embodiment, and futurity along the lines of a rigid, regulatory binary gender system.

This section will focus on the racialization of transgender subjects and the role of race in discrimination against transgender folks, both in terms of anti-trans violence and in terms of discrimination in accessing care. I will also discuss the necropolitics surrounding trans bodies of color and both the disruption that this body causes to mainstream LGBT activism and the value that is extracted from those bodies in death. Finally, this essay will conclude with a consideration of transgender citizenship while considering the normativity that has characterized contemporary queer claims for citizenship and an emerging transnormativity that reproduces problematic and racist notions of visibility and proper citizenship.

Race and Trans Necropolitics

Recent queer scholarship has pointed to both the abandonment and the circulation of trans bodies of color in the employment of queer politics. Ultimately, the status of trans bodies of color, especially trans feminine bodies of color, and their racialization become articulated through violent means that relegate these bodies to the realm of necropolitics. Achille Mbembe distinguishes his concept of necropolitics from Foucault's concept of biopower. As opposed to biopower, which emphasizes the *maximization* of life for certain populations, necropower is the power of the sovereign to decide who will live and who will die, and thus who is disposable.¹⁰⁷ Mbembe defines necropolitics as "contemporary forms of subjugation of life to the power of death," and notes that necropolitics and necropower is a way of accounting for the instrumentalization of death in the form of *death-worlds*, defined as "new and unique forms of social existence in which vast populations are subjected to conditions of life conferring upon them the status of living dead."¹⁰⁸

For trans feminine people of color, the necropolitical cannot be distinguished from racism and the racialization that function within systems of economic abandonment, discrimination, violence, and incarceration that create a trans death-world. Mbembe identifies race as crucial to the politics of death that is inherent within biopower, and thus necropower. He writes, "In the economy of biopower, the function of racism is to regulate the distribution of death and to make possible the murderous functions of the state."¹⁰⁹ Thus, within necropolitics, we can see racism as an instrumentalization that marks certain populations as disposable, marking them for death through complex systems of racialized violence that maintain the

¹⁰⁷ Achille Mbembe, "Necropolitics," in *Public Culture* 15 (2003): 27.

¹⁰⁸ Ibid, 39-40.

¹⁰⁹ Ibid, 17.

function of the late-modern state. Here, I want to point to some examples that clarify the ways in which race is instrumentalized to create a death-world for trans-feminine people of color.

As mentioned in the previous section, in the United States transition related expenses are not covered by medicare and are excluded in the Affordable Care Act. Barriers to accessing transgender specific care that are both economic and discriminatory happens disproportionately along racialized lines, disproportionately affecting trans feminine people of color and black trans feminine people in particular. These barriers to care, which must be characterized as necessary, life-saving, and thus in the realm of the politics of life and death cause transgender people to find other ways of finding income. Trans people often face discriminatory employment practices, and often turn to selling drugs or sex work in order to cover transition costs, and this primarily affects transgender women of color, and leads to high rates of police abuse, high rates of suicide attempts, and rates of incarceration higher than that of the general population.¹¹⁰

Additionally, it is important to consider the high number of murders of trans feminine people of color as a site not only of transphobia but also of racialized violence. Sarah Lamble's look at the Remembering Our Dead Project and the Transgender Day of Remembrance (TDOR) shows how the violence committed against trans-feminine people of color can be decontextualized from systemic causes of violence through politicized acts of remembrance. As Lamble notes, these acts reduce violence to a momentary and individual realm and she writes, "the trans murder victim emerges as the product of an individual hatred or fear rather than the result of the accumulative effect of social institutions (such as legal, economic, and political systems) that are founded on, and perpetuate, complex hierarchies of power and violence (such

¹¹⁰ Grant, et al. "Injustice at Every Turn," 65-163.

as White supremacy, patriarchy, and heteronormativity).”¹¹¹ Lamble sees these projects as rituals that not only deracialize narratives surrounding anti-trans violence, but also perform a political strategy that increasingly emphasizes legal and punitive action that are individual focused approaches to fighting forms of discrimination.¹¹² This spectacularization of trans bodies of color, and the deracialization of the violence committed against those bodies, creates white, sympathetic onlookers as witnesses who are not only complicit in racialized systems of violence, but also invoke the “claiming” of those bodies, thus including trans people of color in social movements only in death.¹¹³

C. Riley Snorton and Jin Haritaworn also analyze the place of the deaths of trans bodies of color within LGBT social movements, recognizing the ways in which those deaths create a trans necropolitics, wherein the spectacularized deaths of trans people of color become vital to homonormative political projects that are actively invested in gentrification, tourism, and security, which all rely on racialized forms of violence and the concealment of race as a factor in discrimination against sexual minorities.¹¹⁴ Additionally, they note that these deaths “[secure] a newly professionalizing class of experts in the realm of life” that relies on extracting value from the deaths of trans people of color.¹¹⁵ They show this through the particular example of the death of Tyra Hunter, showing how elite members of LGBT social movements benefited from the afterlife of her death through their own post-mortem re-signification, deracialization, and sanitation of her death, which made her story more palatable for and incorporable into

¹¹¹ Sarah Lamble, “Retelling Racialized Violence, Remaking White Innocence: The Politics of Interlocking Oppressions in Transgender Day of Remembrance,” *Sexuality Research and Social Policy* 5 (2008), 28.

¹¹² Ibid, 29.

¹¹³ Ibid, 34-38.

¹¹⁴ C. Riley Snorton and Jin Haritaworn, “Trans Necropolitics: A Transnational Reflection on Violence, Death, and the Trans of Color Afterlife,” in *The Transgender Studies Reader 2*, ed. by Susan Stryker and Aren Z. Aizura (New York: Routledge, 2013), 66-75.

¹¹⁵ Ibid, 67.

mainstream gay politics.¹¹⁶ Snorton and Haritaworn note that in this way, the afterlives of trans bodies of color circulate, whereas in life they were “immobilized, barred from spaces designated as white (the good life, the Global North, the gentrifying inner city, the university, the trans community).”¹¹⁷

Similarly, Elijah Ediv Edelman identifies this vitality of the death of trans-feminine people of color to homonormative and homonationalist projects as “homonecronationalism,” where the function of “letting live and letting die” marks which queer subjects are able to be visible in ideologically acceptable and homonormative ways, and which bodies, who are “exceptional” to the mainstream LGBT paradigm, are marked as disposable, and thus marked for death.¹¹⁸ Here, Edelman draws on Jasbir Puar’s concept of homonationalism and the terrorist to argue that trans-feminine people are treated as “terrorists” to “homonormative desires in nationhood,” insofar as they are “always-already-criminalized as economic deviants.” Puar notes that the “mechanics of queerness as a regulatory frame” includes “erecting celebratory queer liberal subjects folded into life (queerness as subject) against the sexually pathological and deviant populations targeted for death (queerness as population).”¹¹⁹ In this context, trans-feminine people of color as terrorist are marked for death as a population, *because* they pose a threat to queerness as subject to the nation, and indeed queer desires for citizenship within the nation. Trans-feminine people of color and their deaths are therefore marked as zones of “exception” where their deaths are seen as acceptable by virtue of the ways in which their bodies subvert and threaten the regulatory power of not only the state, but of white, queer elites who create the acceptability of their own citizenship, and thus the acceptability of their *right to live* by

¹¹⁶ Ibid, 68-71.

¹¹⁷ Ibid, 74.

¹¹⁸ Elijah Ediv Edelman, “‘Walking While Transgender’: Necropolitical Regulations of Trans Feminine Bodies of Color in the US Nation’s Capital,” in *Social Justice: Queer Necropolitics*, 175.

¹¹⁹ Cited in Edelman, 175.

abandoning less-desirable racialized others and defaulting to acceptable forms of neoliberal visibility.

As Sarah Lamble points out, in recent years as more race and class-privileged queer and trans people have been inscribed within forms of neoliberal citizenship, the focus of mainstream queer politics has shifted from a critique of the carceral state to an investment in punitive punishment for discrimination against them.¹²⁰ These queer investments in punity are investments in state violence that is seen as justified and necessary. Lamble writes that “state violence is offered as a solution to such anxieties on the false promise that such practices will offer security and safety to those who embrace them,” and this state violence is offered as a way of disposing those who threaten the benefits of “the contemporary neoliberal political order.”¹²¹ These investments in the carceral state are inevitably investments in the reproduction and maintenance of the colonial legacy of the carceral state, in which persons of color have disproportionately been imprisoned: Lamble calls this an investment in “state racism and violence.”¹²² Trans feminine people of color are also disproportionately imprisoned, and given Lamble’s contention that the prison is another site of necropolitics, trans people of color are once again relegated to the realm of necropolitics.

Queer investments in carceral logics are another example of exceptionalizing and accepting the death-worlds that trans feminine people of color live in every day. It is also worth mentioning that the abandonment of transgender issues by LGBT activists in the US and elsewhere has historically been a method for making gains on the front of gay rights. Jessi Gan’s essay about Sylvia Rivera shows how the radical activist eventually became very distraught and

¹²⁰ Sarah Lamble, “Queer Investments in Punitiveness: Sexual Citizenship, Social Movements, and the Expanding Carceral State,” in *Social Justice: Queer Necropolitics*, 151.

¹²¹ Ibid, 152.

¹²² Ibid, 161.

tired of backroom deals that removed protections for transgender people and LGBT homeless youth in order to pass more palatable gay rights legislation.¹²³ This abandonment shows a certain collusion between activism and the law which produces and maintains the boundaries of proper citizenship and devotion to the nation. With the interweaving of gay rights discourse, gentrification, and homonormativity, mainstream LGBT activism has sewn a landscape of capital accumulation. Returning again to Edelman, it becomes apparent that trans feminine people of color are considered disruptions in capital accumulations, and hence as being disposable and void of value because they do not fit into the logics of citizenship that LGBT rights activism has created. Edelman emphasizes that this is also a spatialized logic which plays out through the gentrification of urban space. Edelman sees gentrification as “a kind of necrocapitalistic reformation of space” that thus “renders bodies that stand in the way of capital productivity as pathological and malignant tumors in an otherwise healthy expansion of capially productive landscapes.”¹²⁴ Thus, only in death are trans feminine people able to add value to this capital productivity, because they are no longer in the way of a queer, neoliberal agenda that is complicit in racist processes like gentrification. Ultimately, their exclusion produces the protection of proper, political citizenship for homonormative subjects who are complicit in the here and now, and who are complicit in destroying and denying a future to those who threaten their own political and economic security. In this way, it is important to think back to the ways in which queer citizenship has historically been fought for, and the ways in which notions of transgender citizenship are being defined along the same problematic, racist lines of proper, productive, neoliberal normativity.

¹²³ Jessi Gan, “Still at the Back of the Bus,” in *The Transgender Studies Reader 2*, eds. Susan Stryker and Aren Z. Azura, (London: Routledge, 2013), 297-299.

¹²⁴ Edelman, 177.

Conclusion: Transgender Citizenship and Transnormativity

Lauren Berlant describes citizenship as “a status whose definitions are always in process” and as “continually being produced out of a political, rhetorical, and economic struggle over who will count as ‘the people’ and how social membership will be measured and valued.”¹²⁵ Her conclusions lead Emily Grabham to recognize that “rights, participation, and identity still work as mobilizing concepts within many definitions of citizenship.”¹²⁶ This conception of citizenship also reflects the question of who is human, or who is counted as human, and with the heuristic of “intimate citizenship” and “sexual citizenship,” centered around the public matter of private intimacies, it has become a way of accounting for the “flows of people, technologies, media, and ideas across the globe.”¹²⁷ There are also anxieties surrounding a citizenship around intimacy and the politics of recognition (recognizing, for example, that transgender people *are* citizens and *are* humans who deserve human rights), because the “responsibilities” of such citizenship also risks reinscribing and reinforcing disciplinary power.¹²⁸

Indeed, normative notions of transgender citizenship are reinforcing the disciplinary power of medical knowledge, institutions, and economic distribution over various subjects. Surya Monro and Lorna Warren write that transgender citizenship, while overlapping with feminist and sexual citizenship models, offers us a distinct approach that puts a *range of genders* to the fore of concerns about citizenship.¹²⁹ Notions of transgender citizenship, which are centered around autonomy and self-determination of gender identity and expression, are inevitably connected to consumer citizenship in the U.S. context because gender reassignment

¹²⁵ Lauren Berlant, *The Queen of America Goes to Washington*, 20.

¹²⁶ Ibid.

¹²⁷ Ibid, 36

¹²⁸ Ibid, 37

¹²⁹ Surya Monro and Lorna Warren, “Transgender Citizenship,” *Sexualities* 7 (2004): 357.

surgery is seen as “elective” and is thus not covered by insurance, and thus in the realm of being a consumer. Judith Butler notes that conceiving of trans surgery in terms of consumer citizenship accepts that transition is an act of autonomy and concludes that this leaves us with the question of how citizenship is to be conceived.¹³⁰ Grabham then notes that this autonomy may indeed reinforce the binary gender system and also marks the moment of citizenship as one's entry into the market and this entry depends on social status and access to resources.¹³¹ Certainly, the data provided by the National Gay and Lesbian Task Force and the rising concerns of psychiatric and medical practitioners about the relationship between the economic aspects of transition and the dire economic consequences of transgender people point to the ways in which conceiving of *a technology of embodiment* as elective, and a consumer good, also marks a disciplinary system of economic, legal, and medical regulation that determines who can have access to care. By conceiving of transgender health-care as elective, it also undermines the stake of effective, and widely available transgender healthcare: it is not elective, but necessary for many people, and even a matter of life and death.

Furthermore, conceiving of transgender citizenship in terms of legal protection, punity, and medicalization performs the work of creating a type of trans-normativity that is invested in notions of patriotic citizenship that place trust in the law, the state, and the medical complex to regulate the gender binary in a fair and equitable manner, not unlike gay and lesbian rights activists who think that marriage is the answer for their own protected status. All of these things perform the work of adding value to life and deciding which (white) lives may perform a proper, visible, patriotic citizenship, and thus are able to live a livable life, and which lives cannot, and are thus unlivable, unintelligible, and marked for death.

¹³⁰ Judith Butler, *Undoing Gender*, 85.

¹³¹ *Ibid*, 44.

In their essay, “Queer Politics and Anti-Blackness,” Dean Spade and Morgan Bassichis write, “the civil and social death of black people forms the basis on which white life and citizenship become knowable.”¹³² Spade and Bassichis’ look at this claim in the context of queer politics, and argue that white gay and lesbian visions of their own social reproduction, narratives about their imperiled social status, and appeal to punitive legal protections and logic, work to perpetuate anti-blackness by positing a mythical narrative of post-racism, investing in the racist carceral state, and putting forward arguments for gay and lesbian legal equality that are invested in narratives of upstanding white rights to citizenship and delinquent, deviant, and disposable black people that threaten the security of white people.¹³³

In thinking of a trans-normativity that reinscribes anti-blackness, we can return to the ambiguous construction of the transgender child by Dutch researchers. The way the researchers characterize an idealized subject for treatment as one who does not have family issues and other concomitant psychiatric disorders, and the unmarked whiteness of the imagined child performs the work of imagining a certain type of *arrival* or a subject who *can* arrive and who *can* become a healthy, gender normative citizen. The responsibility of citizenship that is ultimately conferred to a transgender child is also in some ways the returning of the heterosexual “gift” of kinship and risks reinforcing gender normativity. Additionally, characterizing the lifesaving potential of these procedures while simultaneously ignoring the racialized political economy of the medical complex also reinforces the fact that some factors make a life livable, while other lives are abandoned altogether by the structure of a neoliberal medical marketplace. Even more insidious is the ways in which the disposal of those less desirable lives create the conditions that make other lives livable and indeed, marks those subjects as recognized citizens who are protected by

¹³² Dean Spade and Morgan Bassichis, “Queer Politics and Anti-Blackness,” in *Social Justice: Queer Necropolitics*, 195.

¹³³ Ibid, 195-204.

and valued by the state. As Foucault notes, racism justifies the murderous function of the state because racism acts as a securitizing mechanism: it protects and promotes the safety, the life, and the proliferation of the “good race” through the death of the “bad race.”¹³⁴

Foucault identifies eugenic practices and war as sites where this has occurred, but he acknowledges that this is still a crucial function to the state. Queer politics has been a large part of this history, both through the historical resistances to medical and scientific knowledge production about queers that contained racialized fears about gender, sexuality, and deviance, and more recently by incorporating racism into its strategy for securitizing citizenship rights for white, privileged queers. Contemporary concerns about securitizing transgender citizenship rights is not an exceptional space where these racialized logics do not operate. In fact, various actors, including clinicians, activists, and scholars that are rallying behind transgender health and safety concerns are still appealing to the concept of patriotic citizenship in troubling ways: by creating normative universal narratives of transgender experience and identity, invoking the need for punity in regards to transgender discrimination, and extracting value from the deaths of trans feminine people of color. Overall, it becomes crucial to ask what our politics might look like in light of these historiographies of resistance, racism, and queer politics. How can we consider transgender health, rights, and protections in ways that resist abandoning racialized others? Can we consider queer and trans politics frameworks that deprivilege these concepts in favor for more truly liberatory, intersectional, and coalitional politics?

It is important to recognize that rallying behind transgender health concerns and fighting transphobia means addressing issues such as structural racism, discrimination on the job and housing market, and discrimination and lack of support for transgender youths. The failure to do

¹³⁴ Michel Foucault, “17 March 1976,” in *Society Must Be Defended: Lectures at the Collège de France, 1975-1976* (New York: Picador, 2003), 244-245.

so is indeed another project of imagining a future subject in that it fails to imagine that certain trans lives are livable. In turn, the penalty is erasing the possibility for a body to do anything at all: it erases a horizon of possibilities and leaves us finding a transgender futurism centered on incarceration and death. Furthermore, we must deprivilege the exclusionary rights discourses that are invested in the necropolitical, and thus invested in upholding white supremacy and state power as a regulatory, disciplining mechanism. Instead, we need a queer and trans politics that is anti-racist and centered on prison abolition and the destruction of economic systems that work to exclude, immobilize, and dispose of people of color. We might also think of the ways in which visibility, as a logic and privileged mode of being in relation to a national culture, can be exclusionary, inaccessible, and predicated on the disposal of certain lives. Visibility for some is not always something possible, or indeed, visibility is not always legible and should not have to be legible on the terms of a transnormativity. Instead, we should realize that gender expression should be a matter of self-determination, and not an invitation to read or discern one's gender based on one's body. The possibility of such a reality relies on anti-racism and a deprivileging of the medical institution and the state in determining how trans lives should be lived. The focus, rather, should be to realize how trans lives *are* being lived.

Finally, I want to consider the ways in which these transformations can *feel* impossible, especially under such normative, political landscapes of abandonment. As Biassichis, Lee, and Spade show us, we must recognize that there is already work being done by various organizations to reclaim the radical legacy of queer politics.¹³⁵ They call for us to reimagine and join projects that directly address individual lives that are at risk of being swallowed up, abandoned, or incarcerated. So even in the face of those who might say that prison abolition,

¹³⁵ Morgan Bassichis, Alexander Lee, and Dean Spade, "Building an Abolitionist Trans and Queer Movement with Everything We've Got," in *The Transgender Studies Reader 2*, ed. by Susan Stryker and Aren Z. Aizura (New York: Routledge, 2013), 660-663.

trans liberation, and the destruction of white supremacy are “impossible,” they call on us to not characterize our politics as “impossible,” because they are *possible*. Indeed, the risk of conceding to impossibility is nothing short of the death and erasure of those trans lives that are *loved* and *needed* in this world, and whose value is not in death but in the very fact of their existence as living, breathing, human beings.

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